

Chapter 28

Sexual Disorders

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Sexual disorders can be the source of great suffering to people, sometimes due to embarrassment, sometimes due to physical pain, sometimes due to missed positives (e.g., affiliation, intimacy pleasure), and sometimes due to illegality. Although medical research has produced some useful medical, and in some cases surgical, treatments, behavioral approaches are usually first line treatment due to their efficacy, safety, and cost.

At the end of this chapter, the reader will be able to

1. Identify sexual disorder in a primary care setting
2. Describe a first line of behavioral and medical intervention
3. Identify when referrals might be more appropriate

Case Vignette 28.1.1 Presenting Situation: Lewis Stevens

Mr. Stevens is a 28-year-old man who teaches 5th grade in the public school system. He comes to see you because of a “masturbation problem” at the primary care clinic where you work. He says he does not feel his masturbation activities are appropriate and would like help to decrease his libido. When asked about his history, he states that he has had a standing problem with alcohol abuse that has gotten worse in the last couple of years, which is about how long he has been working as a teacher. He also reports having been molested as a child. The client is hesitant to give any details about his presenting problem; he simply repeats that he would just like help with his masturbation problem. With continued questioning, the client eventually reveals that he generally masturbates three or four times per week.

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Please proceed with the problem-based approach!

The only thing that can be clear from the presentation so far is the lack of information. The presenting problem does not seem necessarily problematic, and the presenter clearly seems to be withholding information. Because his masturbation habit is not abnormal in frequency, further information should be sought about what is “inappropriate” or problematic about the behavior.

Case Vignette 28.1.2 Continuation

With prompting, the client admits that frequency is not the problem; he would like to never masturbate again—the content of his fantasies is the problem. He says that while he has never acted on his fantasies, during masturbation he fantasizes about early pubescent girls and views child pornography. He expresses concern that, while this fantasy has been present as long as he can remember, with the daily exposure to the 10-year-old girls in his class, the fantasies are more realistic and pervasive. He confides to you that he has become interested in a specific girl in his class and has started buying her gifts and wants to invite her for tutoring after class.



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Pedophilia as a sexual orientation is generally not considered curable. Although there have been no conclusive genetic studies performed on pedophiles as a population, some circumstantial evidence suggests one etiological possibility is an intrauterine neurohormonal process with lifelong effects (Quinsey, 2003). In recent years the treatment goal with pedophilic patients is not necessarily to remove all sexual urges, but instead to help the clients control pedophilic urges, keeping them as thoughts instead of actions. Daily interactions with children would make this more difficult. While it is a good sign that he has not yet acted on his urges (or at least admitted that he has), the fact that he has been forming a personal relationship with a specific girl is more troublesome, as this may be “grooming behavior” that can lead to physical contact.

The DSM-IV-TR states that, for a person to meet the diagnostic criteria for pedophilia, he (or she, although female pedophiles are far less common) must meet the following conditions: recurrent intense sexually arousing fantasies, sexual

urges, or behaviors involving sexual activity with a prepubescent child or children; either acting upon these urges or experiencing significant distress or impairment as a result of urges or fantasies; time duration of at least 6 months; and age of at least 16 years and 5 years older than the child or children being fantasized about.

Characteristics of the paraphilic disorders are summarized in Table 28.1.

Another consideration at this point is the issue of mandated reporting. Requirements differ from state to state, but in general, a report must be made when “the reporter, in his or her official capacity, *suspects* or *has reasons to believe* that a child has been abused,” as well as when the reporter has access to definitive knowledge of such abuse (Child Welfare Information Gateway, 2005, *italics added*). As a mandated reporter in a primary care clinic you are only required to report your suspicions and are not required to take on an investigative role. In this case your patient has asserted that he has not acted on his urges, so there may not be anything to report. You need to report child molestation, not pedophilic urges. However, when treating a pedophile, the clinician must be sure to refer to local laws and other resources (local child protective services) regarding mandated reporting. Consulting with peers is often helpful.

Table 28.1 DSM-IV-TR paraphilic disorders

All of the following disorders have the following criteria (DSM-IV-TR):

1. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving these specific stimuli
2. The person has acted on these urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty

Name	Stimulus
Exhibitionism	Exposure of one's genitals to an unsuspecting stranger
Fetishism	Non-living objects (e.g., female undergarments, body) ^a
Frotteurism	Touching and rubbing against a non-consenting person
Sexual masochism	The act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer
Sexual sadism	The act (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person
Transvestic fetishism	Cross-dressing
Voyeurism	The act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity
Paraphilia not otherwise specified	Examples include, but are not limited to, telephone scatology (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine)

^aAdditional criteria: The fetish objects are not limited to articles of female clothing used in cross-dressing (as in transvestic fetishism) or devices designed for the purpose of tactile genital stimulation (e.g., a vibrator)

Case Vignette 28.1.3 Conclusion

*The first and foremost behavioral prescription for Mr. Stevens is to find a new job. Relapse prevention is the treatment with the most evidence for treating child molestation among pedophiles. A principle of this model is that pedophiles should eliminate contact with children for the rest of their lives, and this should be especially true for one-on-one contact. He finds a faculty position at the local community college teaching education. Additionally, he has agreed to have a trusted family member (in this case, his brother) put parental controls on his computer to block him from viewing child pornography. He reports that working with adults instead of children and staying away from pornography has helped diffuse his urges. Because he has not acted on the pedophilic urges, he is prescribed an SSRI instead of a more intensive treatment with testosterone-reducing medication to reduce his sexual desire and afford him more control over his urges. He is also referred to a sex-specific therapist, who begins a regimen of weekly cognitive behavioral therapy (CBT), and he is asked to purchase and work through the evidenced-based self-help book, **Sexual Addiction Workbook**, by Sbraga-Penix and O'Donohue. He finds that his fantasies do diminish, and he never acts on them.*



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Removing exposure to children is the obvious and necessary first step in treating pedophilia. This may also include removing or reducing Internet access, if this is a common form of child exposure for the client. Testosterone-reducing prescriptions such as Depo-Provera have been found effective in treating pedophilia, theoretically due to the idea that the reduction of libido will increase the ability to control pedophilic urges. This extreme treatment, however, may not be necessary for a client who has been able to control these urges on his own, even with factors that might make this difficult (i.e., alcohol use and daily interactions with children). Serotonin-selective reuptake inhibitors (SSRIs) are less intrusive and have been found effective in reducing sex drive.

When assessing and treating pedophilia, it is important to note that minimization and denial are common, and therefore self-report should not be the only source of information. People with this disorder only tend to seek treatment when they get caught; therefore it is often possible to obtain collateral information from the legal sources, such as a parole officer. Objective assessments with instruments, such as the strain gauge or penile plethysmograph which indicate arousal from deviant stimuli, can add to the database whenever their use is feasible; however, these assessments can be difficult and expensive to administer.

It is essential to assess for immediate risk when assessing a patient with pedophilia. In the current example, the immediate risk would be to the children in his class. More often, child sexual abuse occurs within the home, and an immediate safety plan should be made if any children live in a home with the client. It is extremely rare for females to exhibit pedophilic or other paraphilic behaviors.

People with pedophilia require treatment with a specialist. Experts in this field use objective testing, such as plethysmography, and are often members of the Association for the Treatment of Sexual Abusers. For more information on how to select a qualified sex-specific therapist, refer to the *Stop Child Molestation Book* (Abel and Harlow, 2001). Pedophilic patients should continue to have a treatment relationship with a physician, so pharmacological treatment remains an option if needed. In this case, Mr. Stevens received medication to help with the urges and a referral to a sex-specific therapist for more intensive intervention. These therapists are sometimes also called sex therapists; however, “sex therapist” can also refer to a marriage or couples counselor. The naming conventions are not important, but finding a therapist who specializes in deviant sexual behavior is important.

Three classes of medication have shown benefit in the treatment of paraphilic behaviors such as pedophilia: SSRIs, antiandrogen hormones, and luteinizing hormone-releasing hormone (LHRH) agonists. There is evidence that the SSRI sertraline and the antiandrogen cyproterone acetate in particular may have the beneficial effect of decreasing deviant sexual behavior while not decreasing non-deviant sexual behavior. One expert author in the field has suggested an algorithm for treating paraphilic behaviors by starting all cases with CBT, a relapse-prevention program, and an SSRI. For moderate cases, titrated doses of oral antiandrogen may be used, while for more severe cases, antiandrogen may be given intramuscularly. Treatment for catastrophic cases includes a weekly high-dose LHRH agonist or antiandrogen injection to completely suppress all endogenous androgens and sex drive (Bradford, 2001).

Case Vignette 28.2.1 Presenting Situation: Joshua Templar

Joshua Templar is a 42-year-old man who comes to your family medicine clinic. He insists he is in need of Viagra® (sildenafil). Although he has not lost complete erectile function, he is often unable to maintain an erection during prolonged sexual encounters. He says this medication is the only thing that will help him “keep up” with his wife, who is 31 years old. He is not interested in discussing the problem in depth, and appears uncomfortable with the topic. You are not convinced that sildenafil is the best option for Mr. Templar, but he insists that he knows what he needs. He adds that when he was on vacation in Costa Rica last summer the waiters at the resort restaurants routinely provided him with sildenafil and that before he left he purchased a supply to use at home. His supply ran out a few months ago.



Please proceed with the problem-based approach!

Erectile dysfunction (“Male Erectile Disorder” in the DSM-IV-TR) can have both psychological and physiological causes. There is evidence that the majority of diagnosed cases have psychological rather than general medical causes (Skaer et al., 2001). More often than not, there is some interaction between the two pathways.

A simple way to test for organic causes is asking patients if they awake with an erection and, if they do, about the quality of the erection. If this information is not available another method of gaining this information is a nocturnal penile tumescence test. Men without organic erectile dysfunction will generally have erections with every cycle of REM sleep throughout the night, which is called nocturnal penile tumescence (NPT). Several assessment devices are available for NPT, including the stamp test and the strain gauge. A stamp test works by putting adhesive “stamps” (similar to postage stamps) around the penis before sleeping. If the sealed row of stamps is broken during the night, this would be evidence that organic functioning is intact. Similarly, the snap gauge consists of a sleeve that has several “snaps” down the shaft. The gauge is useful in that it assesses not only whether any tumescence was achieved, but also the length of the turgidity.

Mr. Templar’s age raises some concern, as erectile dysfunction does not generally occur before the age of 50.

Case Vignette 28.2.2 Continuation

After repeated prodding during his intake, you establish that Mr. Templar is pre-diabetic and fairly sedentary and that he smokes about two packs of cigarettes a day. He is overweight with a body mass index of 34, and he has a family history of myocardial infarction at an early age. Additionally, he says that he and his wife get along and communicate well and have had a healthy sex life in the past. You suggest that he quit smoking, exercise regularly, and modify his diet. He seems unsatisfied with your recommendation but leaves the appointment without vocal protest. You schedule a follow-up appointment for 1 month later.



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Mr. Templar's cardiovascular risks call for further investigation and may account for the early age of onset of erectile dysfunction. Behavioral prescriptions should target cardiovascular risk factors, because smoking, high glucose levels, and sedentary habits are likely contributing factors, if not the primary cause, of erectile dysfunction.

Case Vignette 28.2.3 Conclusion

Mr. Templar returns 1 month later, smelling of smoke and appearing the same as he had appeared during the first visit. He reports that he has been trying to cut back on smoking and to eat better, but to no avail. He again asks you for the prescription for Viagra®. You relent and write a sildenafil prescription, but not without a conversation. You not only counsel Mr. Templar that you understand how difficult it can be to make health behavior changes, but also explain the potential risks of letting these behaviors persist. You also give him a pamphlet about erectile dysfunction and request that he read the whole thing. You insist that Mr. Templar schedule a follow-up appointment to monitor blood pressure and metabolic labs, either with yourself or with a general practitioner of his choice. You also refer the patient to a local dietician and give him information on an online smoking cessation program, such as quintet.com.

Sildenafil is effective in over 70 % of erectile dysfunction reports (Lyseng-Williamson and Wagstaff, 2002). Like related compounds tadalafil and vardenafil, it acts to indirectly increase levels of cyclic guanosine monophosphate (cGMP) in the corpus cavernosum of the penis. Cyclic GMP causes the penis to vasodilate and is normally increased by parasympathetic release of nitric oxide (NO). Sildenafil's direct action is to bind up the enzyme phosphodiesterase type 5, which would otherwise reduce levels of cGMP (Kerins et al., 2001). This process still depends on sexual stimulation to activate the NO/cGMP system and should not cause an erection without sexual arousal.

Since 1990, erectile dysfunction (ED) reporting and request for treatment has nearly doubled, as has the diagnosis of male erectile disorder. In turn, the pharmaceutical treatment has also dramatically increased. While these facts might suggest that ED reporting has been exaggerated since the introduction of sildenafil and related drugs, it may be that the significant increase simply sheds light on the magnitude of the problem and is not necessarily related to over-reporting since the introduction of medications (Skaer et al., 2001). With sildenafil's increase in use, however, care must be taken of its potentially dangerous hemodynamic side effects. This is especially true in combination with nitrate medications, which together can cause dramatic drops in blood pressure (Kerins et al., 2001).

Additionally, there is evidence to suggest that the benefits of prescribing medications for ED may outweigh the costs: "Sildenafil treatment significantly improves quality-of-life related to sexual function and general well being; potential health-care savings may result as these effects trickle down" (Lyseng-Williamson and

Table 28.2 DSM-IV-TR sexual dysfunctions

Hypoactive sexual desire disorder ^a	Deficient or absent sexual fantasies and desire for sexual activity
Female sexual arousal disorder	Inability to attain or maintain physiologic arousal until completion of sexual activity
Male erectile disorder ^a	Recurring inability to achieve or maintain an erection until completion of the sexual activity
Female orgasmic disorder	Delay or absence of orgasm following normal excitement and sexual activity. (SSRI medications frequently cause secondary orgasmic disorders)
Male orgasmic disorder	Delay or absence of orgasm following normal excitement and sexual activity. (SSRI medications frequently cause secondary orgasmic disorders)
Premature ejaculation	Ejaculation with minimal sexual stimulation before or shortly after penetration and before the person wishes it
Dyspareunia ^a	Recurrent or persistent genital pain associated with sexual intercourse. Can be diagnosed in men or women but is most common in women
Sexual aversion disorder	Persistent or recurring aversion to or avoidance of sexual activity. Sexual topics may provoke extreme anxiety
Vaginismus	Recurrent or persistent involuntary spasm of the vaginal muscles that interferes with sexual intercourse. May be related to dyspareunia

^aThese disorders also have a separate disorder listed in the DSM-IV-TR when “due to medical condition.”

Wagstaff, 2002). These authors suggest that sildenafil is a cost-effective option, since empirically based behavioral treatments (such as changes in diet and exercise) might not work in the general population.

One study also suggests that psycho-education combined with sildenafil works better than medication alone; and therefore, psycho-education should be provided along with sildenafil prescriptions (Bach et al., 2004).

Erectile dysfunction is one of the many sexual dysfunctions identified in the DSM-IV-TR and summarized in the Table 28.2.

Case Vignette 28.3.1 Presenting Situation: Tom Roberts

You are a private practice psychiatrist who specializes in gender identity disorders (GIDs). Tom Roberts is a 23-year-old male graduate student who came to see you because he is interested in gender reassignment surgery. He has done his Wikipedia research and would like to begin the process of becoming a woman by living as one for the required time. Mr. Roberts tells you that he has always felt uncomfortable as a man and, even as a child, always believed that he was “a girl inside.” He is very excited about the opportunity to feel “normal,” and wants to start the reassignment process right away.



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Transsexualism, while previously seen as a purely psychological process, has been increasingly understood in neurobiological terms thanks to modern research. Gender differences are well established in the shape and size of brain structure. The differences include the size and shape of cell body clusters, known as nuclei, in the hypothalamus of the brain and in the bed nucleus of the stria terminalis. Recent studies have found multiple male-to-female transsexuals with female bed nucleus characteristics and at least one case has been reported of a female-to-male transsexual with male dimorphic characteristics (Zhou et al., 1995; Kruijver et al., 2000).

Related research has shown that sex hormones have lifelong effects on the human brain. Recent studies demonstrate that cross-sex hormone treatment can alter the morphology of the total brain, particularly the hypothalamus, toward the average brain architecture of the opposite sex (Hulshoff et al., 2006). It is not yet clear how to weigh the relative contributions of genetics and hormonal exposure during pregnancy versus postnatal rearing (Crespi and Denver, 2005). Evidence for a purely hormonally derived differentiation is limited at best (Hrabovsky and Hutson, 2002).

Case Vignette 28.3.2 Continued

You explain to Mr. Roberts that gender reassignment is a long process and not necessarily an entirely positive journey. Mr. Roberts remains enthusiastic. You administer a number of psychological assessments and explain that there are many options he should keep in mind throughout the treatment. He must complete a 12-month period of hormonal treatment while living as a woman before surgery is an option. He could also choose to try hormone-only treatment or learning to adapt to gender identity disorder without any medical intervention. You also explain the risks of both the surgery and the hormonal treatment in great depth and note that one-third of male-to-female transsexuals are anorgasmic post-surgery.

Mr. Roberts is still optimistic about his treatment decision and does not demonstrate any signs or symptoms of a comorbid psychiatric disorder. You refer him to the rest of his gender reassignment treatment team: a surgeon, an endocrinologist, and a clinical psychologist—all with experience treating gender identity disorder. You provide written documents to the endocrinologist of your approval to begin hormonal treatment. After a few months of this treatment, he will be ready to begin his real-life experience of living completely as a woman for a full year.



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Some people find comfortable ways to deal with GID without the team intervention, either with or without psychotherapy. Another large section of the population finds that they can adapt well enough with only the first line hormonal treatment, such as estrogens (for feminization and decreased libido), antiandrogens (to decrease body hair and contribute to feminization), and progestogens (for breast development and psychological effects). While hormone treatment is obviously less intrusive and reversible, it poses potential adverse side effects, including blood clots, weight gain, emotional disorders, liver disease, gallstones, hypertension, and diabetes mellitus. The blots clots can be medically serious, with a possibility of fatality for those with cardiovascular disease (Meyer et al., 2001).

Depending on a psychiatrist's training, the roles of the endocrinologist and the psychotherapist can be wrapped into that of the psychiatrist. The role discussed in this case is only that of assessment. While it is not necessary in all cases, patients undergoing sexual reassignment surgery should receive psychotherapy throughout all phases of the treatment. This can help the client cope with the challenges of the new gender role and also address commonly comorbid disorders, including autogynephilia (arousal due to imagining oneself as a woman) and transvestism (arousal due to cross-dressing).

Case Vignette 28.3.3 Continued

Tom Roberts—now Adele Roberts—comes in for another assessment appointment after having completed the year-long real-life experience phase. She has been living as a woman for a year and has legally changed her name. She remained a student throughout the year, but was fired from her job. She reports this was discrimination against her transgender state. Ms. Roberts shows signs of a mild depression and has lost the enthusiasm that seemed so prominent a year ago. You wonder whether the experience has made her think about whether to progress to surgery for definitive treatment of gender identity disorder. She responds that she wants to complete the process to become a woman but is now dealing with large stressors due to this change. On top of losing her job, she lost health insurance. Her family members have significantly distanced themselves. These responses, combined with objective assessment measures and your overall clinical interview, reassure you that she is a viable candidate for reassignment surgery. At this point, you submit documentation to the surgeon that you believe the surgery is a feasible option for this client.



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The goal of this phase of assessment is to assure that the client is consolidating her gender identity. This would help confirm the hypothesis that her distress will be diminished with the surgery. Ms. Robert's reports of stress at this stage are not uncommon, and the "change of gender role and presentation can be an important factor in employment discrimination, divorce, marital problems, and the restriction or loss of visitation rights with children" (Meyer et al., 2001). Instead of focusing on the individual's adaptability to these understandable stressors, this stage of clinical interviewing instead focuses on the client's ability to function as an adult of the desired sex, including the ability to maintain a job or function in the capacity of a student. Documentation of this functionality should be provided by a third-party source.

In the case of a male-to-female transsexual such as Ms. Roberts, who is attracted solely to men, she would be considered a heterosexual male-to-female transsexual. It is generally accepted that transsexualism is neither dependent on nor related to sexual orientation, although the range of sexual orientation tends to be more diverse in transsexual populations (De Cuypere et al., 2004).

Case Vignette 28.3.4 Conclusion

Ms. Roberts returns 1 year after the surgery for a follow-up assessment. She is no longer experiencing any dysphoria about her gender, but is still adjusting to her new life. When asked if she has any questions, she reports that she has been avoiding her general practitioner because she is not sure what to expect or what evaluations she needs.



Please proceed with the problem-based approach!

Outcome research suggests that regrets concerning the decision to undergo reassignment surgery are fairly rare and that surgery commonly reduces or eliminates the gender dysphoria. On the other hand, "outbursts of regret" have been reported as well as development of borderline personality disorder. Generally, however, reported feelings of regret tend to focus on the functional result of the surgery and not on the treatment decision itself (Lawrence et al., 2005; Olsson and Möller, 2006; Smith et al., 2001). If the surgery successfully produced non-problematic genitals, the individuals remain largely satisfied. The majority of post-operative

transsexuals express an increased satisfaction with their sex life and their new genitals. Female-to-male transsexuals tend to have more difficulty forming relationships after the surgery and sometimes experience pain during intercourse due to the erectile prosthesis.

As a gender specialist, it might be a good idea to inform the client of what she should learn to expect from her general practitioner, as a non-specialist may not be equipped to understand the health needs of a post-operative transsexual. Male-to-female transsexuals should be treated as females in their checkups, including mammograms. The prostate gland is not removed during the reconstructive surgery, however, and therefore the client should request regular prostate exams as well. Additionally, female-to-male patients should still seek annual papanicolaou examinations unless a complete hysterectomy had been performed (Sobralske, 2005).

Review Questions

1. How long must a person have recurrent sexual arousal from a specific stimulus to be diagnosed with a paraphilia?
 - (a) 1 month
 - (b) 6 months
 - (c) 12 months
 - (d) Any amount of time if the arousal is intense enough to require treatment
2. At what point is a doctor mandated to report on pedophilic child abuse?
 - (a) When a patient states they have pedophilic urges
 - (b) When a patient asks for medication to control pedophilic urges
 - (c) When the doctor suspects or has reason to believe a child has been abused
 - (d) None of the above
3. By what mechanism do sildenafil-like drugs benefit erection?
 - (a) Directly on the parasympathetic nervous system
 - (b) Indirectly on the parasympathetic nervous system
 - (c) Directly on the corpus cavernosum vascular system
 - (d) Indirectly on the corpus cavernosum vascular system
4. Before what age is erectile dysfunction generally considered unusual?
 - (a) Before age 40
 - (b) Before age 50
 - (c) Before age 60
 - (d) Before age 70
5. Which of these is a serious medical complication of hormone treatment therapy?
 - (a) New onset diabetes insipidus
 - (b) New onset schizophrenia

(c) Development of brain aneurysms
(d) Development of blood clots

6. What is the most common regret in transsexuals after sexual reassignment surgery?

(a) Regret with the functional result of the surgery, not the treatment decision itself
(b) Regret with the treatment decision itself, not the functional result of surgery
(c) Regret with having to maintain hormone therapy
(d) Regret with not being able to have children in the usual way of their re-assigned gender

7. The most common cause of erectile dysfunction is

(a) Physiological
(b) Psychological
(c) Environmental
(d) A combination of biological and psychological factors

8. According to the Harry Benjamin Standards of Care, it is suggested that individuals seeking sexual reassignment surgery first live as a member of the opposite sex for

(a) 2 months
(b) 6 months
(c) 1 year
(d) 2 years

Answers

1. b, 2. c, 3. d, 4. b, 5. d, 6. a, 7. d, 8. c

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